

FILED MAR 8 1945

Registration District No. **47**

Primary Registration District No. **3008**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(c) Name of hospital or institution: **State Hosp # 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2-44**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **Stoddard**
(c) City or town **Callaway**
(If outside city or town limits, write "RURAL")
(d) Street No. **1st**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Willie McKinnney**
3. (b) If veteran, name war **DK.**
3. (c) Social Security No. **DK.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **10**
year **1945** hour **7** minute **35** M.
21. I hereby certify that I attended the deceased from **5-2-** **1944** to **1-10-** **1945**
that I last saw **him** alive on **1-14-** **1945**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **negro**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **DK**
6. (c) Age of husband or wife if alive **24** years
7. Birth date of deceased **3-24-1901**
(Month) (Day) (Year)

Immediate cause of death **Lymphitis**

8. AGE:
Years **43** Months **8** Days **24**
If less than one day hr. min.

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

MOTHER FATHER
9. Birthplace **DK** (City, town, or county) **9** (State or foreign country)
10. Usual occupation **DK**
11. Industry or business
12. Name **DK**
13. Birthplace **DK** (City, town, or county) **9** (State or foreign country)
14. Maiden name **DK**
15. Birthplace **DK** (City, town, or county) **9** (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury **0**

16. (a) Informant **record**
(b) Address
17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **1-17-45**
(Month) (Day) (Year)
(c) Place: burial or cremation **Columbia mo**
18. (a) Signature of funeral director **J.O. Roberts**
(b) Address **Columbia mo**
19. (a) **1-17-1945** (Date received local registrar) (b) **Josiah Morsieck** (Registrar's signature)

Signature **T.E. Starnell** (M. D. or other)
Address **Fulton mo** Date signed **1/17/45**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

14
1
2

RECEIVED
District Health Officer No. 9.

District File Number

Date Filed 3-24-45

MAR 20 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.